Application

Application of this Medical Policy applies to:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Commercial (HBE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
Extended Family Planning (EFP)

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidelines.

For FIDE Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the member's Medicaid benefit.

For CO-DSNP Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

The Diagnostic and Statistical Manual-Fifth Edition (DSM V) defines gender dysphoria as follows: "Gender Incongruence" refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available."

The World Professional Association for Transgender Health (WPATH) (http://www.wpath.org) is an international, inter-disciplinary organization, which publicizes evidence-based care and clinical guidance in its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 8th Version (SOC). SOC* is the primary reference for this policy.

Individuals, whose birth-assigned gender is male and who have gender dysphoria, are referred to as **Transwomen.**
Individuals, whose birth-assigned gender is female and who have gender dysphoria, are referred to as **transmen.**

Coverage Determination

Authorization **NOT** Required	**Services for Members Less than 18 Years of Age:** 1. Behavioral and medical health **Services for Members 18 Years of Age and Older:** 1. Behavioral and medical health 2. Laboratory testing to monitor treatment of gender dysphoria 3. Pharmacological and Hormonal therapy (Prior authorizations unrelated to the treatment of Gender Incongruence may be required.)
Requires Authorization	**Services for Members Less than 18 Years of Age:** 1. Pharmacological and hormonal therapy that is non-reversible and/or produces masculinization or feminization 2. Pharmacological and hormonal therapy to delay physical changes of puberty **Services for Members 18 Years of Age and Older:** 1. Surgical treatment (outlined below)

Surgical Treatment for Gender Dysphoria:
The following are covered when Criteria for Surgical Treatment for Gender Incongruence have been met.

Surgical Treatment for Gender Incongruence, Gender Reassignment Surgery for Members Less than 18 Years of Age is NOT covered.

Female to male (FTM, transmen)		Male to female (MTF, transwomen)	
Breast reconstruction (e.g., mastectomy	(19303-19304), reduction mammaplasty (19318)	Orchiectomy	54520, 54690
Hysterectomy	58150, 58262, 58291, 58552, 58554, 58571, 58573	Penectomy	54125
Hysterectomy Salpingo-oophorectomy	58661	Vaginoplasty	57335
Colpectomy/Vaginectomy	57110	Colovaginoplasty	57291-57292
Metoidioplasty	55899	Clitoroplasty	56805
Phalloplasty	55899	Labiaplasty	58999
Urethroplasty	53430	Tracheal shave/reduction thyroid chondroplasty: reduction of the thyroid cartilage	31899
Scrotoplasty	55175, 55180	Breast Augmentation- Requires documentation by the physician prescribing hormones and the surgeon that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role	19324-19325.
Electrolysis epilation, each 30 minutes	17380	Electrolysis epilation, each 30 minutes	17380
Laser Hair Removal – Unlisted procedure, skin, mucous membrane, and subcutaneous tissue	17999	Laser Hair Removal – Unlisted procedure, skin, mucous membrane, and subcutaneous tissue	17999

Gender reassignment surgeries/procedures listed in Tables I and II require prior authorization and are covered for transmen or transwomen when documentation submitted confirms that all of the following criteria are met:

- ☐ Member is 18 years of age or older
- ☐ Member has the capacity to make fully informed decisions including consent to treatment.
- ☐ Gender Dysphoria has been diagnosed by qualified health provider(s) and is a persistent diagnosis for at least 6 months
- ☐ Documentation from a qualified health provider(s) with expertise in mental health and transgender care, supporting candidacy for gender-confirming surgery

- ☐ Clinically significant distress or impairment in social or occupational or other important areas of functioning or clinically significant increased risk of suffering
- ☐ Evidence that the member has access to primary care provided by a clinician who has an understanding of gender dysphoria and who can perform and coordinate follow up care including appropriate screenings and monitoring.
- ☐ The treatment plan must conform to WPATH standards and/or to other evidence-based, agreed-upon, external guidelines.
- ☐ * Surgeons must have demonstrated training, experience, and proficiency in performing the requested surgical procedure.
- ☐ Documentation indicating hormone treatment has been provided for at least 6 months or is contraindicated (not required for female to male surgery, non-genital)

Exclusions and Limitations

- Surgical Treatment for Gender Incongruence, Gender Reassignment Surgery for **Members Less than 18 Years of Age**
- Reversal of gender reassignment surgery or reversal of surgery to revise secondary sex characteristics.
- Gender reassignment services for members who are dissatisfied with their assigned gender in the absence of clinically significant distress or impairment.
- Procedures for the preservation of fertility such as the procurement, preservation, and storage of sperm, oocytes, or embryos.
- Procedures other than those listed below are excluded.
- **Excluded procedures include but are not limited to the following:**
    - Dermabrasion,
    - Hair transplants,
    - Hair removal (except in the case of electrolysis epilation for preoperative site hair removal),
    - Lipectomy,
    - Osteoplasty - facial bone reduction,
    - Otoplasty,
    - Rhinoplasty,
    - Rhytidectomy,
    - Scar Revision,
    - Subcutaneous injection of filling material,
    - Tattooing or tattoo removal (except tattooing of the nipple/areola related to a mastectomy),
    - Voice modification surgery

- Procedures designed to enhance masculinity or femininity or to alter body contours for aesthetic reasons are considered cosmetic and are excluded, example; procedures related to facial feminization.

Covered CPT codes when meeting criteria:

19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)	**57106**	Vaginectomy, partial removal of vaginal wall
19303	Mastectomy, simple, complete	**57107**	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
19304	Mastectomy, subcutaneous	**57110**	Vaginectomy, complete removal of vaginal wall
19316	Mastopexy	**57111**	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
19324	Mammaplasty, augmentation; without prosthetic implant	**57291**	Construction of artificial vagina; without graft
19325	Mammaplasty, augmentation; with prosthetic implant	**57292**	Construction of artificial vagina; with graft
19350	Nipple/areola reconstruction	**57335**	Vaginoplasty for intersex state
31899	Unlisted procedure, trachea, bronchi	**58150**	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
53430	Urethroplasty, reconstruction of female urethra	**58180**	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
54125	Amputation of penis; complete	**58260**	Vaginal hysterectomy, for uterus 250 g or less
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	**58262**	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
54690	Laparoscopy, surgical; orchiectomy	**58275**	Vaginal hysterectomy, with total or partial vaginectomy
55175	Scrotoplasty; simple	**58280**	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
55180	Scrotoplasty; complicated	**58285**	Vaginal hysterectomy, radical (Schauta type operation)
56625	Vulvectomy simple; complete	**58290**	Vaginal hysterectomy, for uterus greater than 250 g
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)	**58291**	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less	**58550**	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less

58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	**58552**	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g	**58553**	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with	**58554**	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s
17380	Electrolysis epilation, each 30 minutes	**17999**	Unlisted procedure, skin, mucous membrane and subcutaneous tissue

Covered ICD 10 codes when meeting criteria:

Description	ICD-10 Diagnosis	ICD-10 Procedure	CPT
Surgical Services-Transgender Inpatient	F64.1, F64.2, F64.8, F64.9, Z87.890	0HTT0ZZ,0HTU0ZZ, 0HTV0ZZ, 0H0T0ZZ, 0H0U0ZZ, 0H0V0ZZ, 0HBT0ZZ, 0HBU0ZZ, 0HBV0ZZ, 0TQD0ZZ, 0TUD07Z,0VQ50ZZ, 0VU507Z, 0UB04ZZ, 0UB14ZZ, 0UB24ZZ, 0UB54ZZ, 0UB64ZZ, 0UB74ZZ, 0UTG0ZZ, 0UT00ZZ, 0UT07ZZ, 0UT17ZZ, 0UT27ZZ, 0UT57ZZ, 0UT67ZZ, 0UT77ZZ, 0UT97ZZ, 0UTC7ZZ, 0UT04ZZ, 0UT14ZZ, 0UT24ZZ, 0UT54ZZ, 0UT64ZZ, 0UT74ZZ, 0UT94ZZ, 0UTC4ZZ, 0UT10ZZ, 0UT20ZZ, 0UT50ZZ, 0UT60ZZ, 0UT70ZZ, 0UT90ZZ, 0UTC0ZZ, 0UT9FZZ, 0UB014ZZ, 0UB74ZZ, 0H0T0ZZ, 0HQT0ZZ, 0HQU0ZZ, 0HQV0ZZ, 0H0T0JZ, 0H0U0JZ, 0H0V0JZ, 0HRT0JZ, 0HRU0JZ, 0HRV0JZ, 0HUT0JZ, 0HUU0JZ, 0HUV0JZ, 0VTS0ZZ, 0VTSXZZ, 0VR90JZ, 0VRB0JZ, 0VRC0JZ, 0VT90ZZ, 0VT94ZZ, 0VTB4ZZ, 0VTC4ZZ, 0VTB0ZZ, 0VTC0ZZ, 0W4M0Z0, 0W4M070, 0U7G0ZZ, 0UQG0ZZ, 0W8NXZZ, 0UBJ0ZZ, 0UBJXZZ, 0HST0ZZ, 0HSU0ZZ, 0HSV0ZZ, 0HSWXZZ, 0HSXXZZ, 0HRT07Z, 0HRU07Z, 0HRV07Z, 0HRW07Z, 0HRWX7Z, 0HRX07Z, 0HRXX7Z, 0UBMXZZ, 0UTM0ZZ, 0UQG7ZZ, 0UGGXZZ, 0UUG07Z, 0WQN0ZZ,	19301, 19303, 19304, 19316, 19318,53430, 55175, 55180, 55899, 57110, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661, 19324, 19325, 31899, 54125, 54520, 54690, 56805, 57291, 57292, 57335, 58999, 19350, 56625, 56800, 56810, 57106, 57107, 57111, 58180, 58260, 58275, 58280, 58285, 58290, 58541, 58542, 58543, 58544, 58550

Description	ICD-10 Diagnosis	ICD-10 Procedure	CPT
		0UBG0ZZ, 0UTG7ZZ, 0UBG7ZZ, 0UQF7ZZ, 07TC0ZZ	
Surgical Services- Transgender Outpatient	F64.1, F64.2, F64.8, F64.9, Z87.890		19301, 19303, 19304, 19316, 19318,53430, 55175, 55180, 55899, 57110, 58150, 58262, 58291, 58552, 58554, 58571, 58573, 58661, 19324, 19325, 31899, 54125, 54520, 54690, 56805, 57291, 57292, 57335, 58999, 19350, 56625, 56800, 56810, 57106, 57107, 57111, 58180, 58260, 58275, 58280, 58285, 58290, 58541, 58542, 58543, 58544, 58550

References:

- The World Professional Association for Transgender Health (WPATH*). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.* Version 8. 2022. URL address: http://www.wpath.org.
- American Psychiatric Association. (May 2013, Updated 2022). *Diagnostic and Statistical Manual of Mental Disorders.* 5th Edition (DMS 5). Arlington, VA: American Psychiatric Publishing.
- RI EOHHS Gender Dysphoria/Gender-Nonconformity Guidelines. November 2015

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference

CMP Cross Reference:	CMP-012-Plastic Surgery
Created:	December 2015
Annual Review Month:	December
Review Dates:	12/15/2016, 1/9/18, 1/4/19, 3/4/20, 3/10/21, 3/16/22, 3/8/23, 12/6/23, 12/11/24, 12/10/25
Revision Dates:	6/30/2016, 12/15/2016, 3/10/21, 12/6/23, 12/11/24, 12/10/25
CMC Review Dates:	1/10/2017, 1/9/18, 1/9/19, 3/4/20, 3/10/21, 3/16/22, 3/8/23, 12/6/23, 12/11/24, 12/10/25
Medical Director Approval Dates:	1/5/2016, 1/26/2017, 4/12/18, 1/9/19, 3/4/20, 3/10/21, 3/16/22, 3/8/23, 12/6/23, 12/11/24, 12/10/25
Effective Date:	1/5/2016, 7/1/2016, 1/30/2017, 4/12/18, 1/9/19, 3/4/20, 3/10/21, 3/16/22, 3/8/23, 12/6/23, 12/11/24, 12/10/25

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any

decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.